

Partners in Recovery and Resilience

Annual Report • Fiscal Year 2008
with Selected Highlights from 2009

Maryland Mental Hygiene Administration



Martin O'Malley, Governor

Anthony G. Brown, Lieutenant Governor

John M. Colmers, Secretary, Department of Health and Mental Hygiene

Renata Henry, Deputy Secretary, Behavioral Health Services

Brian Hepburn, M.D., Executive Director, Mental Hygiene Administration

Clarissa's Story of Recovery

When I ended up in the ER at Hopkins, I began to recognize that not taking my meds properly was causing me to have mental health problems. I misunderstood the doctor's diagnosis of a back problem and thought she said I had a terminal illness.

When I got home my husband was furious the doctor told me that, until it dawned on him that I hadn't been taking my meds! From that day forward I was on my way to recognizing that I needed to go to mental health professionals and take care of myself both physically and mentally; my whole person, and not just part of me.

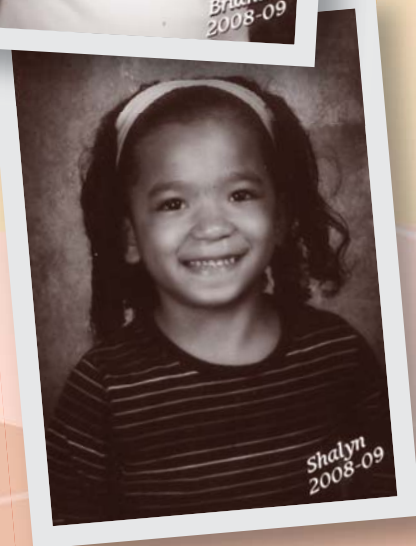
My family was instrumental in giving me hope. My husband was the most important person. He accepted me the way I was, whether I was sick or well. His concern for me was greater than my concern for myself. He saw me as this beautiful black woman who was going to conquer the world. I saw myself as crazy and delusional. He saw my recovery in me before I saw it in myself. I learned to have faith in myself. I learned to believe in myself.

My mother also gave me hope. She changed her attitude when she saw me struggling with recovery. She learned that I was not weak and out of control, and she learned to respect me. She came to see mental illness from my perspective. The sense of stigma in my family was tremendous. My older son believed it was a weakness. I had to teach him about mental illness.

I began to meet so many consumers who were in recovery that I began to get hope that I too could experience recovery. It was just a way of life for them. If I only had the hope and belief in myself that it could happen for me, I too could recover.

A program which trained people with mental illness in human services opened my eyes to the truth that I wasn't alone in this mental illness. There were other people like me. Being around others with mental illness helped me grow stronger every day. I saw people who didn't have my strengths and I was able to help them. I saw others with strengths I didn't have and they were able to help me. Our relationships were give and take. We were able to feed off each other. Even when I got a paycheck for helping people, it never stopped. I was getting paid for something I loved to do.

Now I am in total recovery and working at MHA to help improve the public mental health system in Maryland. It is my job to support consumers throughout the entire state! Things have changed so much. At one time, I wanted to end my life and my children's lives. Now I know that the future will be OK for them. I don't play with my recovery at all. It is my way of life now.



Letter from the Executive Director



We are pleased to share with you this report for the Mental Hygiene Administration (MHA). This year's report highlights goals MHA and its partners have reached as part of a collaborative effort to transform Maryland's Public Mental Health System (PMHS) into a more coordinated and efficient system that supports recovery and resilience across the life span.

We are proud that Maryland received one of the top grades given by the National Alliance for Mental Illness in its "Grading the States" report for 2009 and is the only state in the country to receive three major federal mental health system change awards—a Mental Health Transformation State Incentive Grant (Transformation grant), a Children's Mental Health Initiative grant (System of Care grant), and a Community Alternatives to Psychiatric Residential Treatment Facilities Medicaid demonstration waiver (Demonstration Waiver). Our receipt of these awards represents national recognition of the state's cutting edge work to improve services to Marylanders with mental illness.

Over the past year, the PMHS's noteworthy success in enhancing evidence-based practices (EBPs) and promising practice models for adults led to expansion of all existing models and the development of a new EBP for co-occurring mental health and substance abuse disorders. One of our EBPs, the Supported Employment program, received a significant national award for its impressive outcomes. Working with On Our Own of Maryland, our main consumer-run organization, we have made great strides in introducing promising practices that support recovery, including training, technical assistance and Wellness and Recovery Action Plans. Additionally, Mental Health First Aid provided ongoing training to help lay persons recognize and assist individuals in mental distress, similar to providing CPR for physical health problems.

In the children's area, in addition to the System of Care grant received in September 2008, the state received two other federal grants to strengthen foster care families and to prevent youth suicide. Maryland was also one of six states selected to participate in a national policy academy to address the needs of transition-aged youth. Because of these successes, Maryland has been recognized as a national leader for its ability to develop cross-systems fiscal and policy support for services to keep children with intensive needs in their home communities.

The PMHS continues to improve access to services. Using technology to improve access to mental health services, MHA launched a web-based resource site, Network of Care (NOC) for Behavioral Health, which provides local, state, and national information to help consumers and families access services and manage their mental illness. MHA also launched a Veterans' Initiative to help service men and women access behavioral health services within the Veterans' Administration, and is one of only two states to develop a NOC site for veterans.

Maryland takes pride in developing and delivering state-of-the-art mental health services and will continue to do so while remaining fiscally and clinically responsible. Our partnerships have made the difference.

A handwritten signature in orange ink, appearing to read "John M. Hepburn".

Brian Hepburn, M.D.
Executive Director, Mental Hygiene Administration

Mission

The mission of the Mental Hygiene Administration is to create and manage a coordinated, comprehensive, accessible, culturally competent, and age appropriate system of publicly funded services and supports for individuals who have psychiatric disorders and, in conjunction with stakeholders, provide treatment and rehabilitation in order to promote resiliency, health, and recovery.

Vision

Our vision is to have a comprehensive accessible array of public and private services. These services will help individuals empower themselves to achieve the highest level of participation in community life.

Our Partners

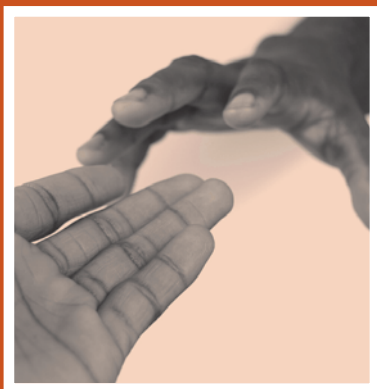
MHA's mission could not be accomplished without its partnerships with consumers, families, youth, advocates, academic institutions, and federal, state and local agencies.

Key Facts About Maryland's Public Mental Health System (PMHS)

- The Mental Hygiene Administration (MHA) is the agency within the Department of Health and Mental Hygiene (DHMH) responsible for the delivery of public mental health services.
- The majority of these services are delivered under the fee-for-service system, a system that allows providers to serve eligible individuals and then bill the state for those services. Most of these services (86%) are funded by Medicaid, with a 50% federal match for most expenditures.
- MHA operates seven inpatient psychiatric facilities and two residential treatment centers for children and adolescents.
- MHA funds services to individuals who are not eligible for Medicaid, but because of the severity of their illness and their financial need, are qualified to receive state-subsidized services.
- MHA, in collaboration with local mental health authorities known as Core Service Agencies (CSAs), manages the Public Mental Health System (PMHS). MHA and the CSAs are assisted in managing the PMHS by an Administrative Services Organization (ASO), which authorizes services, makes payments and manages data collection and reporting.



“Creative empowerment is my most effective form of therapy. To write, paint, sing, cook or design gives me an outlet to embrace my illness [and] to make it positive, productive and empowering.”

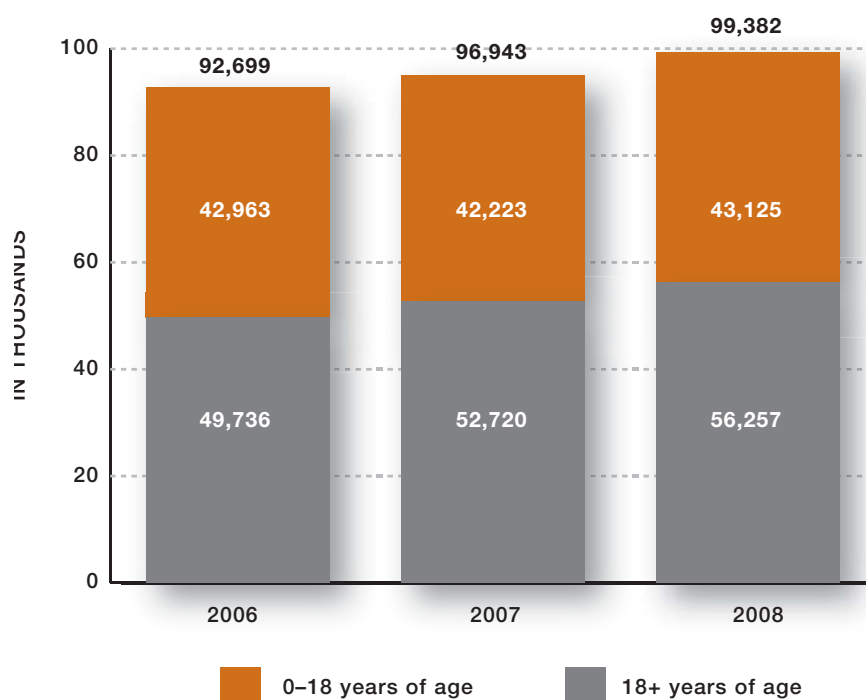


“I’m still learning about myself, because that’s what recovery is about, too. Still getting to know when I’m tired, when I need to go to bed, when I need to exercise, when I need to eat right. I have a lot of things that I need to work on today.”

Marylanders Served by the Public Mental Health System

The number of individuals served in the fee-for-service system increased from 92,699 in FY 2006 to 99,382 in FY 2008, a seven percent increase. The number of adults (18+) served has increased by 13 percent since FY 2006, while the number of children and adolescents served showed only modest growth.

Number of Consumers by Age Group



Source: MAPS-MD Data report #MARF0004 based on claims paid through 11/30/08.

An almost equal percentage of those who received services in the fee-for-service system were males and females. In FY 2008, 57 percent of people served were adults, 43 percent were children and youth. The racial distribution of those served by the fee-for-service system has remained relatively steady across fiscal years. Most consumers are either Caucasian (40%) or African American (46%).

Demographics of Consumers Served in the Fee-For-Service System in 2008

SEX	RACE	AGE
Male 51%	African American 46%	0-17 43%
Female 49%	Caucasian 40%	18 and Over 57%
	Other* 14%	

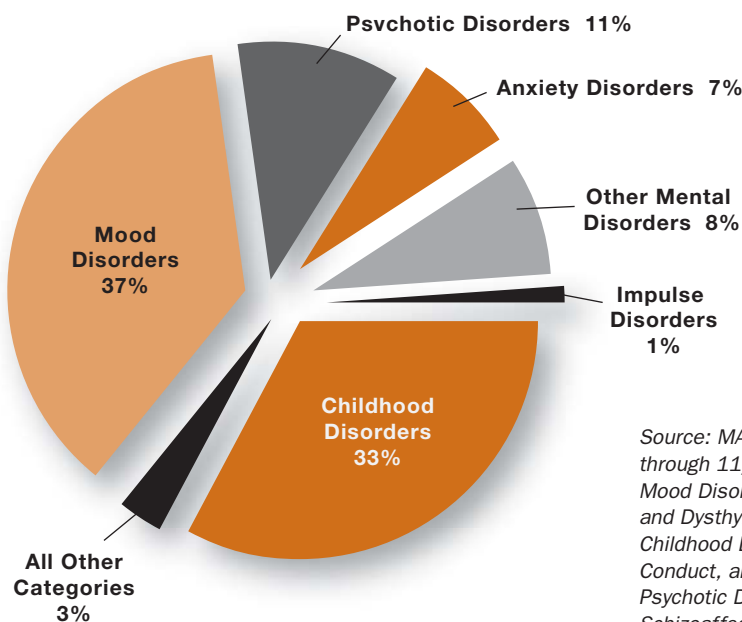
*Other includes Asian, Native American, Hispanic and Unknown.

Source MAPS-MD Data Repository based on claims paid through 11/30/2008.

Diagnoses of Consumers Served by the Fee-for-Service PMHS

The fee-for-service system serves individuals with a range of psychiatric diagnoses. The three most common diagnostic groupings for children and adolescents are attention deficit disorders, adjustment disorders, and major depression. The most common diagnoses for adults are major depression and bipolar disorder, followed by other non-psychotic mental disorders and schizophrenia. The vast majority of consumers served by the fee-for-service system had serious emotional disorders (75 percent of children) or serious mental illness (65 percent of adults), underscoring the fact that the PMHS primarily serves those with very serious mental illness.

Distribution of Initial Primary Diagnoses in the Fee-For-Service System - FY 2008



Source: MAPS-MD Data Repository based on claims paid through 11/30/2008.

Mood Disorders, All ages – Includes Major Depression, Bipolar, and Dysthymia

Childhood Disorders, Children only – Includes Adjustment, Conduct, and Other Childhood Disorders

Psychotic Disorders, All ages – Includes Schizophrenia, Schizoaffective, and Other Psychotic Disorders

Other Mental Disorders, All ages – Includes Physiological Malfunctions Arising from Mental Factors

Anxiety Disorders, All ages – Includes Panic, Obsessive-Compulsive, and Post-Traumatic Stress Disorders

Impulse Disorders, –All ages - Includes Personality and Impulse Disorders

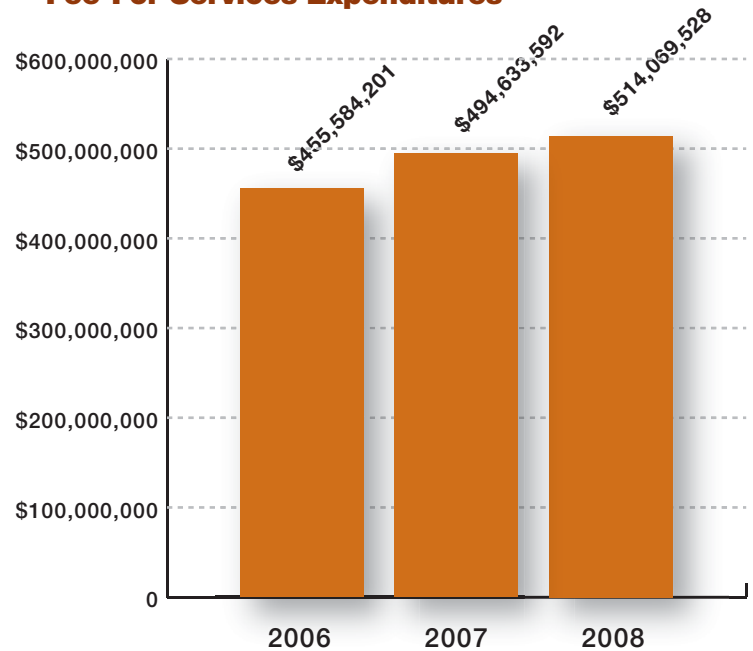
Expenditures and Funding Sources for Marylanders in the Public Mental Health System

A little over a decade ago, the state launched its fee-for-service system, which allowed consumers to choose among many different providers meeting appropriate standards and willing to accept fee-for-service payments, and it also allowed the state to claim a federal match on most expenditures. Fueled in part by the growth in Medicaid-eligible individuals, increasing numbers have received public mental health services. Associated expenditures through the fee-for-service system rose by 13 percent from FY 2006 to FY 2008. These expenditures are a reflection of the growth in Medicaid expenditures as well as a small cost of living adjustment for providers.

In FY 2008, 68 percent of total expenditures were for community-based services, including those in the fee-for-service system and those served through grants and contracts as shown in the chart (below, left).

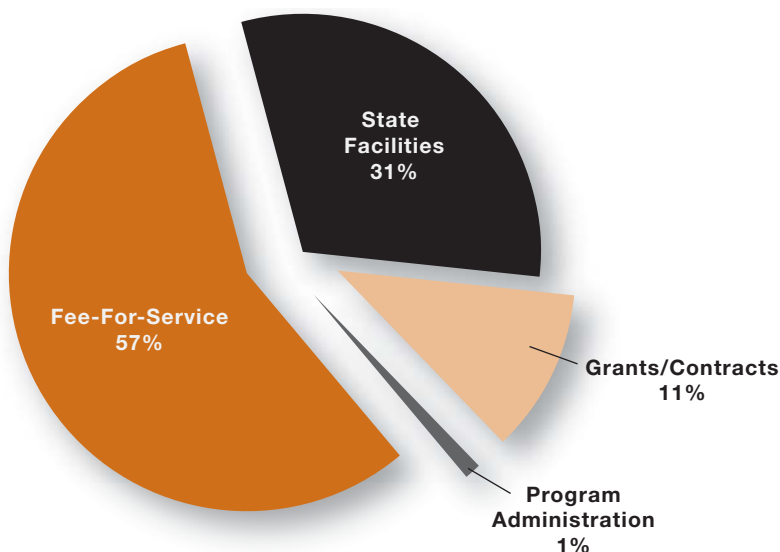
As shown in the chart on the next page, 87 percent of total expenditures in the fee-for-service system are for services reimbursed by Medicaid.

Fee-For-Services Expenditures



Note: Expenditures for MHA Headquarters and Medicaid Community Pharmacy are not included. Source: Fiscal Years 2006 -2008 Maryland Budget Books

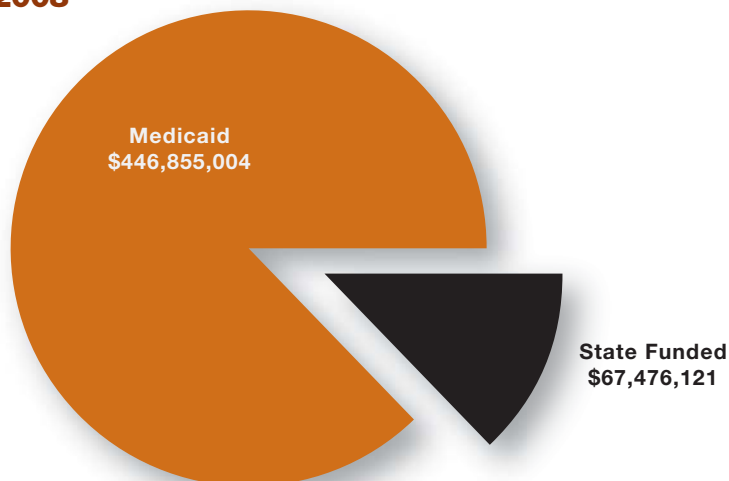
Total Community and State Facility Expenditures - FY 2008



Note: Expenditures for MHA Headquarters and Medicaid Community Pharmacy are not included. Source: Fiscal Years 2006 -2008 Maryland Budget Books

Non-Medicaid expenditures include those for Medicaid-eligible recipients, non-Medicaid reimbursable services provided to Medicaid recipients, and services for individuals within state-only Medicaid eligibility categories. The non-Medicaid expenditures are targeted to services most likely to enhance outcomes that would otherwise not be obtained under a standard Medicaid benefits package. For example, the housing costs associated with residential rehabilitation for people leaving state hospitals and residential crisis services are not covered by Medicaid, yet they are an important part of the continuum of services to prevent people from unnecessarily using higher levels of care.

Fee-For-Service Expenditures by Funding Source - FY 2008



Source: MAPS-MD Data Report #MARF0004 based on claims paid through 11/30/2008

MHA aggressively pursues federal matching funds for services provided under the PMHS. As part of this effort, MHA has received a number of federal waivers which allow it to provide cutting edge services not generally eligible for Medicaid reimbursement and then claim a federal match on those services. Waivers are obtained by demonstrating that the new services are cost-effective and achieve impressive outcomes for the people served.

In November 2007, Maryland expanded eligibility for the Health Choice program, Maryland's statewide program providing health care to most Medicaid recipients. This expansion will increase the number of people with access to services covered by Medicaid, including mental health services.

MHA continues to contract with CSAs and other public and private partners to support programs that provide specialized services which are either not included in the standard Medicaid benefits package, or do not lend themselves to payment through the fee-for-service system.

Approximately \$54.7 million in state general funds and \$21.8 million in federal dollars were awarded through these contracts in FY 2008, for a total of \$76.5 million. Federal grants include: the Community Mental Health Services Block Grant, Projects for Assistance in Transition from Homelessness (PATH), Shelter Plus Care (rental assistance and supportive services for people with disabilities who are homeless), Emergency Response Capacity, the Data Infrastructure Grant, the Mental Health Transformation – State Incentive Grant, and a new multi-year System of Care grant for children.

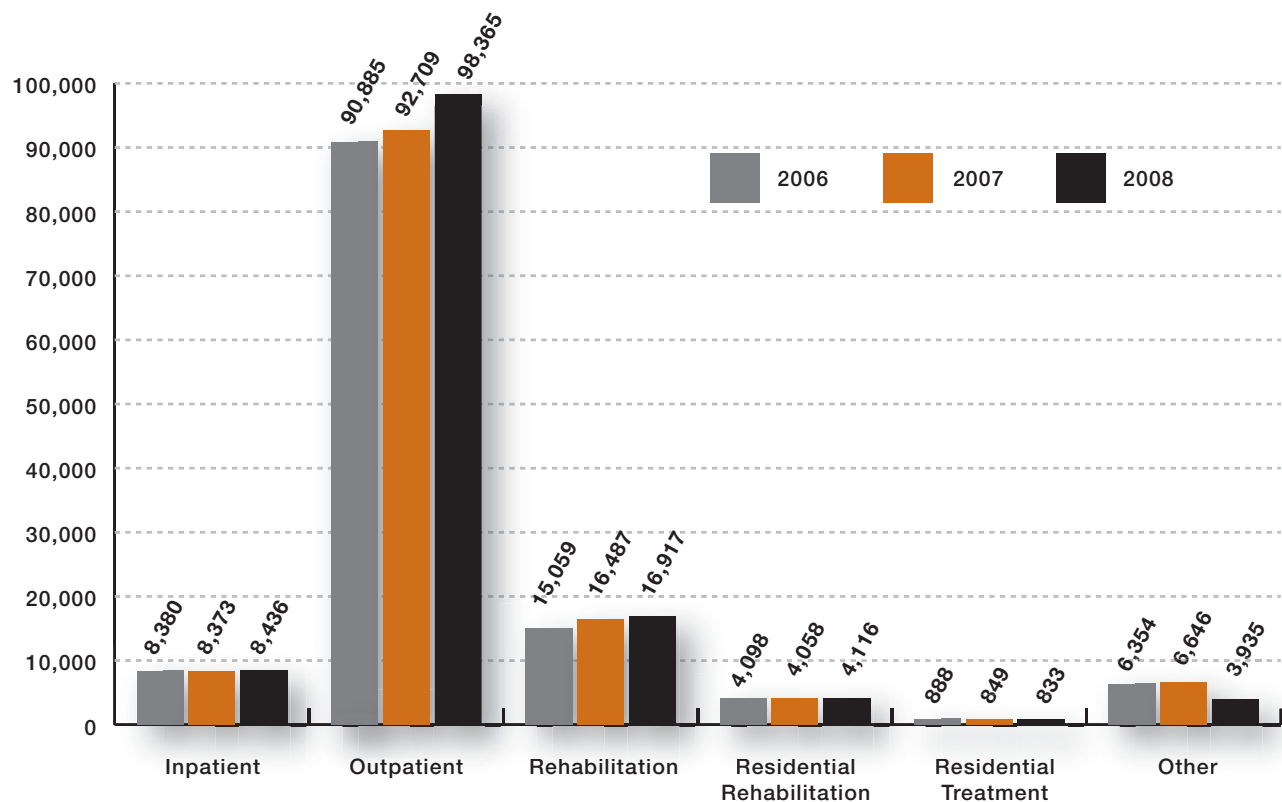


“This has given me the desire, hope and security to strive every day to become a better person. I’m not self-medicating, I’m working part-time, seeking out a home, and life is much more enjoyable.”

Services Purchased and Provided through the Public Mental Health System

The following chart demonstrates that most consumers served by the fee-for-service system receive services in community-based settings. From another perspective, only a minority of consumers are served in inpatient or residential settings. This comports with MHA's commitment to serving people in the least restrictive, clinically appropriate setting.

Number of Consumers Served in the Fee-For-Service System by Service Type



Note: Inpatient includes Inpatient and Purchase of Care. Outpatient includes Outpatient, Partial Hospitalization, Mobile Treatment, Baltimore Capitation Program and Emergency Petitions. Rehabilitation includes Psychiatric Rehabilitation and Supported Employment. Other includes Crisis, Respite and Case Management. As of August 2007, Case Management services were funded through CSA contracts. Consumer counts may be duplicated, since individuals may have received more than one service.

Source: MAPS-MD Data Report #MARF0004 based on claims paid through 11/30/2008.

Between FY 2006 and FY 2008, there have been increases in the number of individuals using community services such as rehabilitation and outpatient services while the numbers served through inpatient and residential services remained relatively stable. As a result, more people are receiving services in less restrictive settings.

Inpatient Services in State Psychiatric Facilities

MHA continues to look for alternatives to hospitalization in state hospitals. There are three main reasons for this effort: people generally prefer treatment in their home community, the costs are lower than at state hospitals and there is an increasing demand by the criminal justice system for services and beds in state hospitals for people involved in the criminal justice system.

One alternative to state hospitalization is the purchase of inpatient care (POC) from private psychiatric hospitals and general hospitals with excess capacity within their psychiatric units. In addition, MHA has funded a number of hospital diversion projects at the local CSA level to ensure that individuals presenting at local hospital emergency departments are diverted to community based treatment when admission to a state hospital is not necessary.



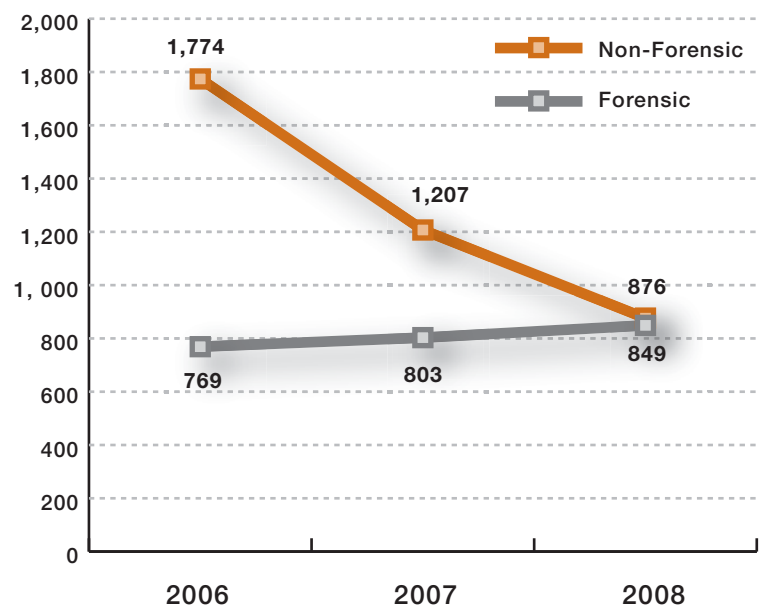
“There are a million reasons to give up, but that’s something I can’t afford to do!”

State Hospital Admissions and Length of Stay

Total admissions to state psychiatric hospitals since FY 2006 have decreased by 32 percent but forensic (court involved) admissions during that same timeframe have increased by 10 percent. As a portion of total admissions, forensic admissions have grown from 30 percent to 49 percent.

As the forensic population within state hospitals expands, the percentage of individuals served in state hospitals discharged within 30 days of admission continues to decline. In FY 2006, for example, 66 percent of those admitted were discharged with a length of stay less than 30 days. In FY 2008, that percentage dropped to 52 percent. This change is because consumers involved in the

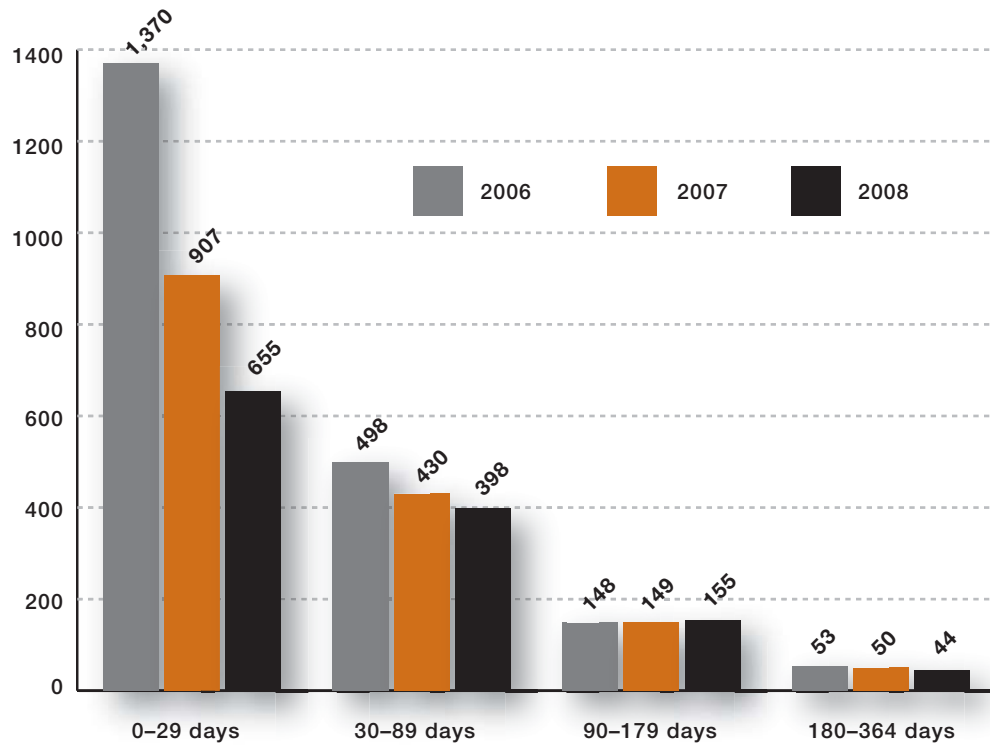
Admissions to State Facilities by Legal Class



Note: Data excludes RICAs and Clifton T. Perkins.
Source: State Hospital Management System (HMIS).

criminal justice system often need court resolution of legal status before they can be discharged from a hospital setting. As the length of stay increases, the total number of people who can be served in a state hospital must decrease, since beds become available less frequently.

State Facility Length of Stay



Note: Length of Stay calculated using admissions in the fiscal year that were discharged in the same fiscal year. Data excludes RICAs and Clifton T. Perkins Hospital.*

Source: State Hospital Management Information System (HMIS).

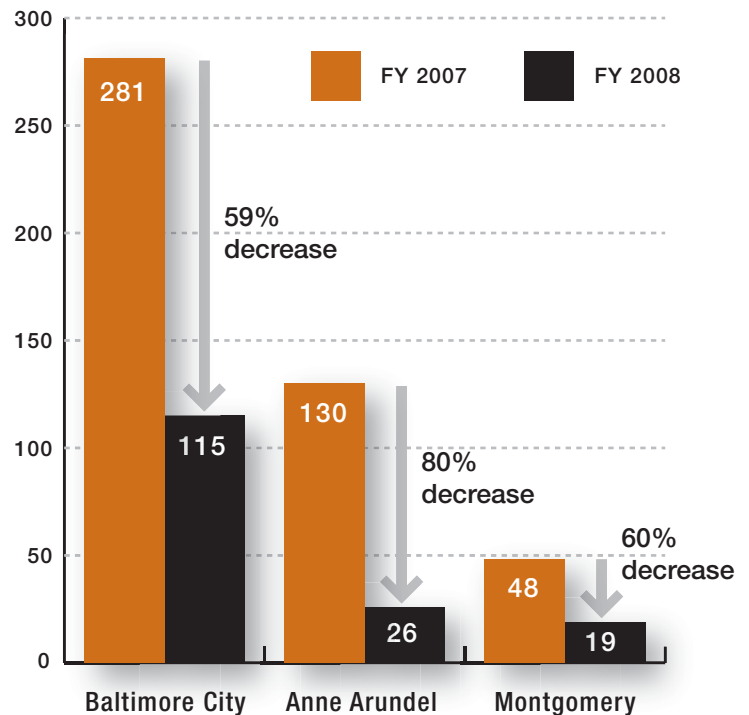
Diversion of People with Mental Illness from Hospital Admission

Hospital diversion projects divert consumers who do not need state hospital care to community-based programs. In select jurisdictions, local CSAs working with the support of MHA, have implemented a continuum of community-based crisis and emergency services, including urgent care and outpatient clinics, mobile crisis teams, respite options, crisis residential treatment, addictions treatment, and residential or crisis support services for children and adolescents. These projects provide mobile crisis evaluation, triage, and referral to minimize the need for emergency room treatment and hospitalization. Of those individuals determined to need inpatient care, most were referred to the less costly alternative of private purchase of care beds in free-standing private psychiatric facilities and in local hospitals with excess capacity in their inpatient psychiatric units.

Hospital diversion projects were initially implemented in FY 2007 in Montgomery and Anne Arundel counties and Baltimore City. In FY 2008, Prince George's and Baltimore counties also developed diversion projects.

These hospital diversion projects have led to dramatic reductions in admissions of uninsured individuals to state hospitals (decreases ranging from 59 to 80 percent for the three programs launched in FY 2007). In addition, in FY 2008, over 1,100 individuals were seen by mobile crisis teams in local hospital emergency departments, of whom more than 44 percent were diverted into community-based programs.

Number of Non-Forensic Admissions to State Psychiatric Facilities from Emergency Departments



Source: State Hospital Management Information System.



“I had the “Flight to Wellness” syndrome. I would get treatment and think I was all better. My diagnosis helped me accept that I had problems and look at my behavior. The diagnosis wasn’t important; I’ve been diagnosed with everything in the book; it was the acceptance that I had problems that was important to my recovery. I don’t like it about myself, but I do have to accept it.”

Purchase of Care Beds in Private Sector

Purchase of Care (POC) admissions to private hospitals increased from 270 in FY 2002 to 1,282 in FY 08, almost quintupling. The POC beds have expanded access to community-based inpatient services for people with mental illness throughout the PMHS.

In FY 2008, the average length of stay for a non-forensic state psychiatric hospital admission originating from an Emergency Department was 30 days. The cost per admission was \$19,200. The average length of stay for a purchase of care admission is nine days, with an average expenditure of \$9,000 — less than half the cost of a non-forensic state hospital admission from an Emergency Department.

Services for Individuals with a Mental Illness Involved in the Criminal Justice System

The PMHS continued to see increases in the number of individuals with court-related charges or involvement in the criminal justice system. To alleviate the increased pressure on the PMHS, particularly state psychiatric beds, MHA increased collaborations with the Judicial System to divert people from incarceration when appropriate, while maintaining compliance with court orders and judicial recommendations.

The PMHS offers a range of services that can prevent an arrest or incarceration (jail diversion) or provide an alternative to psychiatric inpatient admissions. These services include: Crisis Intervention Teams (CIT), Mobile Crisis Teams (MCTs), and Assertive Community Treatment (ACT). CSAs have the discretion to choose which services to develop, with support from MHA.

Crisis Intervention Teams (CIT). Several CSAs have implemented CITs following either the Memphis model, an innovative police-based first responder program of pre-arrest jail diversion for those experiencing a mental health crisis, or a comparable model. The Memphis model of CIT provides law enforcement-based crisis intervention training for helping individuals with mental health crisis. Mobile Crisis Teams or Crisis Response Teams provide an immediate face-to-face response for individuals with acute symptoms.

Mobile Treatment Services (MTS). Another diversion service is mobile treatment. These services provide intensive, assertive mental health treatment and support services delivered by a multidisciplinary treatment team to an adult or a minor whose mental health treatment needs have not been met through routine, traditional outpatient mental health programs. The purpose of MTS is to enable the individual to remain in the community, thus reducing the individual's admissions to emergency rooms, inpatient facilities, or detention centers.

Assertive Community Treatment (ACT). Since 2005, Maryland has offered evidence-based Assertive Community Treatment. These ACT teams also provide intensive, mobile, assertive mental health treatment for people for whom traditional mental health services do not work, and they do so according to a model with strong evidence of effectiveness. As a result, these teams can bill at a higher rate under Medicaid.

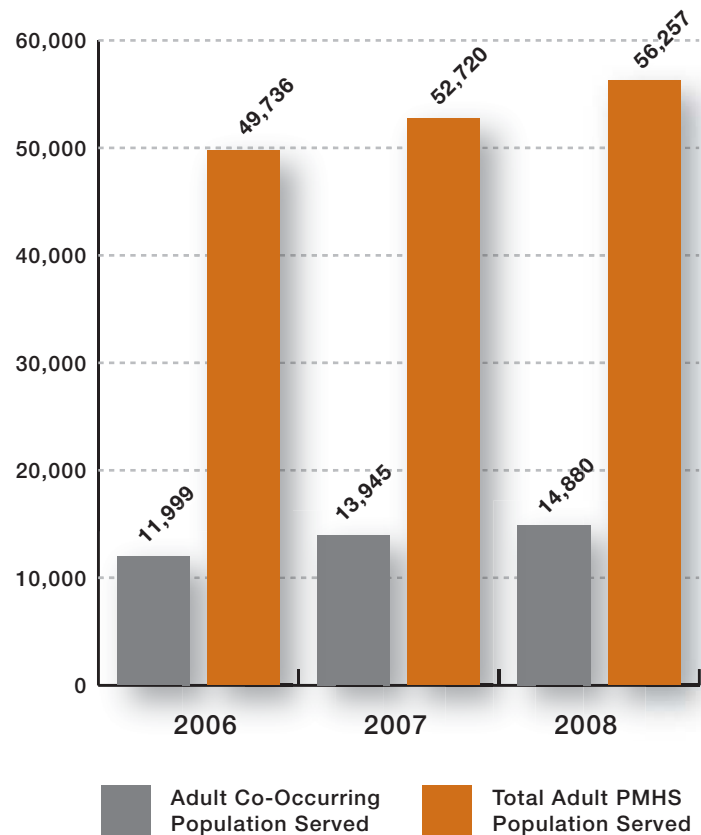


“My story of recovery began a couple of years ago when I went to an On Our Own of Maryland conference and heard a consumer give his story of recovery. Ten years earlier he had had a lot of hospitalizations that were lengthy and difficult, and here he was ten years later traveling around the country giving his recovery journey. And that is my story of recovery.”

Consumers with Co-Occurring Mental Health and Substance Abuse Disorders—A Major Subpopulation

A significant number of individuals served in the PMHS have co-occurring disorders (mental illness and substance abuse). As shown in the chart here (right), the PMHS served close to 15,000 adults with a co-occurring disorder in FY 2008, representing a 24-percent increase since FY 2006. Adults with co-occurring disorders represented 26.5 percent of adults served in the fee-for-service system in FY 2008.

Number of Adults with Co-Occurring Disorders Served in the Fee-For-Service System

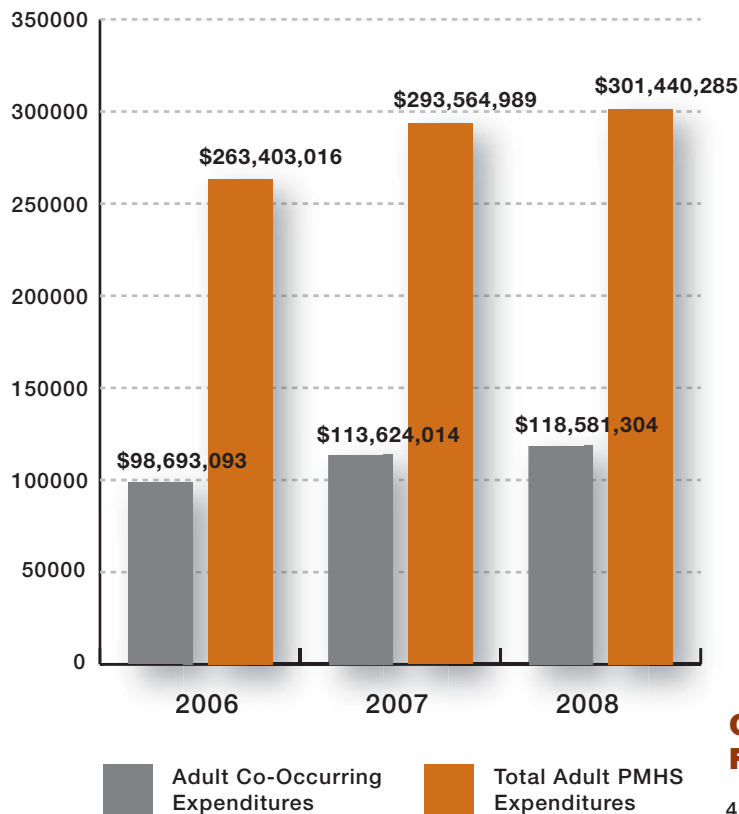


**An individual with a diagnosis of substance abuse and mental illness.
Source: MAPS-MD Data Report #MARS9490 based on claims paid through 11/30/2008*

Working with CSAs, the state Alcohol and Drug Abuse Administration, and other stakeholders, MHA is strengthening coordination and integration of services to improve access for consumers with co-occurring disorders. This collaborative approach is designed to ensure clinically sound services for this population.

As reflected in this chart (next page, top), expenditures for dually-diagnosed individuals with mental illness and substance abuse disorders accounted for 39.3 percent of total fee-for-service expenditures for adults in FY 2008 as compared to 37.5 percent in FY 2006.

Fee-For-Service Expenditures for Adults with Co-Occurring Disorders

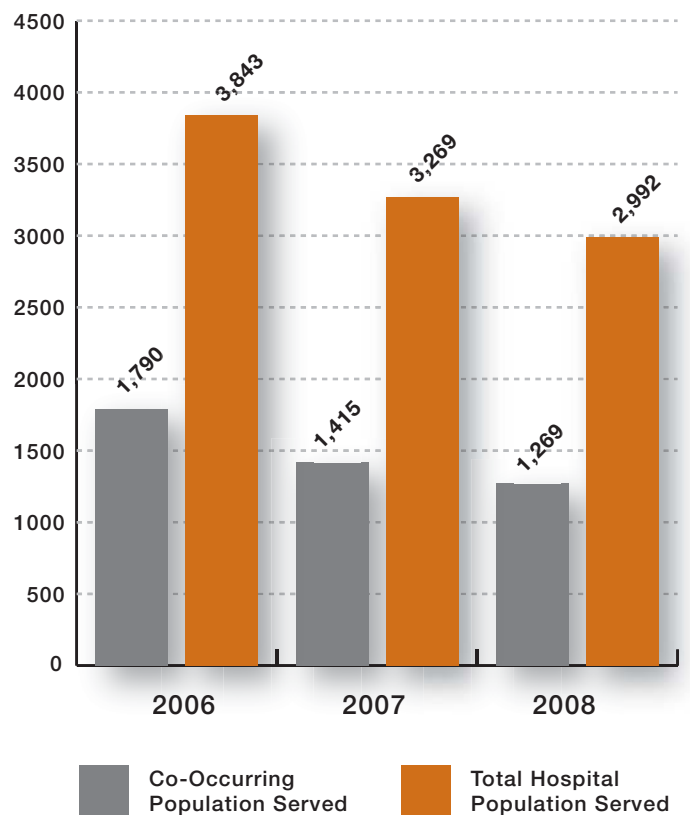


*An individual with a diagnosis of substance abuse and mental illness.

Source: MAPS-MD Data Report #MARS9490 based on claims paid through 11/30/2008.

Over the past three fiscal years, the percent of consumers with co-occurring disorders in state inpatient facilities (excluding those in the two regional institutes for children and adolescents and the state forensic hospital) declined from 46.6 percent to 42.4 percent (see chart below). This reduction results in part from successful hospital diversion initiatives targeted at this group and other at-risk populations.

Co-Occurring Population Service in State Facilities



Note: Data exclude RICAs and Clifton T. Perkins Hospital.

Source: State Hospital Management Information System (HMIS).

Major MHA Accomplishments

Actions That Empower Stakeholders and Promote Systems Change

Anti-Stigma Project Works to Change Attitudes on Mental Illness

MHA and On Our Own of Maryland (OOOMD) continue to collaborate to fight stigma within the mental health system through the Anti-Stigma Project (ASP). In FY 2008, the ASP presented 50 workshops throughout the state, reaching over 3,000 participants. Workshops and training were presented at Wellness and Recovery Centers and in other educational settings, as well as at several local, state, and national conferences. The ASP continued the training with a focus on the impact stigma has in other areas, such as stigma as a barrier to housing, the relationship between stigma and the use of seclusion and restraint, and reducing environmental stigma.

Consumer Quality Team Program Offers Consumers a Critical Opportunity for Input

The Consumer Quality Team of Maryland (CQT) is a consumer and family member run program dedicated to improving quality oversight of the public mental health system by recording and addressing individual consumers' satisfaction with the services received. CQT makes site visits to Psychiatric Rehabilitation Programs and inpatient mental health facilities serving adult consumers. CQT began as a pilot program in three counties in 2006, began an expansion in 2007 and will serve all counties in Maryland by 2011.

New Program Offers Timely Data on Consumers Served by the PMHS

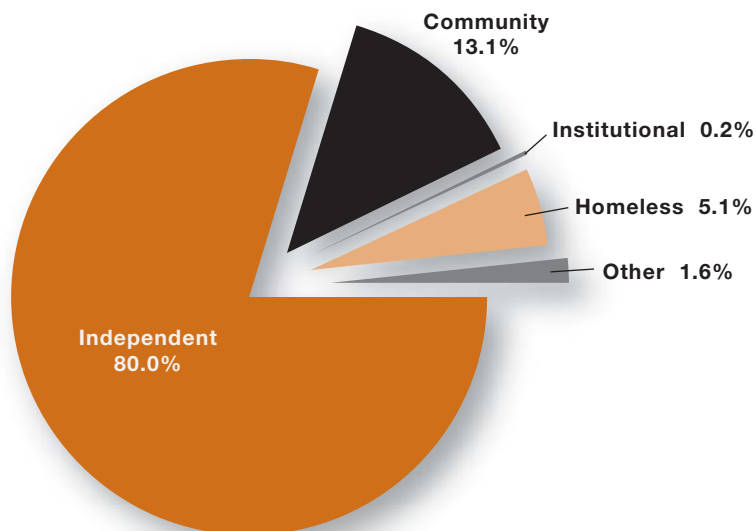
The Outcome Measurement System (OMS), implemented statewide in FY 2007, was developed to collect information ranging from housing to school attendance to substance abuse on people, ages six to 64, who are receiving mental health services in outpatient settings from Maryland's fee-for-service

system. By the end of FY 2008, more than 50,000 individuals had completed at least one OMS interview. Information is collected at the beginning of treatment and every six months thereafter while an individual is receiving treatment. This information makes it possible for MHA to conduct a change over time analysis which helps assess the benefits of treatment.

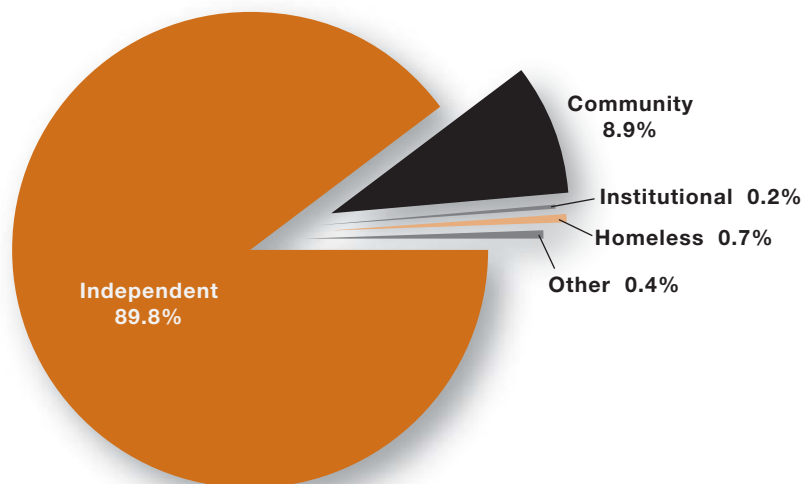
The datamart, a user-friendly website launched in FY 2008, provides summary information about the people who are receiving services, based on the answers to their most recent OMS questionnaire. The datamart is accessible to all stakeholders and the general public at <http://mapsmdreporing.apshealthcare.com>.

The following sample charts illustrate one type of information available from the datamart:

FY 2008 Adult Outcome measurement System Response to "Living Situation"



FY 2008 Child/Adolescent Outcome Measurement System Response to "Living Situation"



Source:
<http://mapsmdreporing.apshealthcare.com/Oms.asp>
 Based on authorizations through 12/31/2008.
 Private residence, boarding house or rooming house (with no supervision provided) are considered "Independent."
 Residential Rehabilitation programs, school or dormitory, Foster Home, Assisted Living, and Crisis Residence are considered to be "Community."



*“I have a mental illness;
the mental illness does
not have me!”*

MHA Actively Promotes Recovery and Resilience Orientation for Adults in the PMHS

Through a contract with On Our Own of Maryland, MHA Transformation sponsored a series of six regional recovery training sessions across the state in early 2008. A total of 605 people attended these sessions, including consumers, CSA staff, and providers of mental health services. Morning sessions featured a presentation on the recovery paradigm, recovery stories from panels of consumers, and smaller group discussions with providers and consumers from the same geographic area. In the afternoon, training focused on change in MHA regulations intended to promote recovery and resilience. Additional recovery training sessions are underway in FY 2009, including specialized training for psychiatrists.

Family Leadership Institute (FLI) Trains Families to Navigate Services for Young Consumers

The Coalition of Families for Children’s Mental Health established a Family Leadership Institute (FLI), which has produced new advocates every year since 2004. FLI provides a training program for families in navigating the child and adolescent mental health service systems in Maryland and in becoming advocates in their communities and the state. Ninety-four families have been trained by the Institute. The statewide FLI curriculum involves a major commitment from family members for participation, which consists of six full-day sessions held on a series of Saturdays.

MHA Promotes Cultural and Linguistic Competence Throughout the PMHS

In January 2008, MHA submitted to the General Assembly a report entitled “Cultural Competency and Workforce Development for Mental Health Professionals.” This marks an important milestone in assuring access of all Marylanders, regardless of race and ethnicity, to mental health services. The report assesses:

- Options for enhancing the cultural competency of mental health professionals;
- Access to appropriate mental health services provided by professionals who are culturally competent to address the needs of the State's diverse population;
- Mental health workforce shortages and potential strategies to use foreign-born and foreign-trained mental health professionals to alleviate shortages; and
- Initiatives to facilitate licensure or certification of foreign-born and foreign trained mental health professionals.

MHA is currently actively engaged in implementing a number of recommendations from this report.

Community Services – Adults

Award-Winning Evidence-Based Practices Grow

Maryland's efforts to promote adoption of evidence-based practices (EBPs) for adults have resulted in implementation of EBP models in the areas of Supported Employment (SE), Assertive Community Treatment (ACT), and Family Psychoeducation (FPE), a treatment model involving family participation. Currently, there are 15 SE, eight ACT, and five FPE programs which meet fidelity standards. Maryland's SE initiative won a 2007 Science and Service Award from the federal Substance Abuse and Mental Health Services Administration (SAMHSA). In FY 2008, work began to develop and implement an EBP project for co-occurring treatment at selected sites.

Web Access to Nationally Recognized Network of Care Now Available across Maryland

In late May 2008, MHA completed statewide implementation of the Network of Care for Behavioral Health, a web-based resource providing simple and fast access to information on local, state, and national behavioral health services. The site also contains a library of mental health articles, links to support and advocacy organizations, reports on legislation, and a password-protected personal folder feature, including space for a consumer's Wellness Recovery Action Plan (WRAP). Over the first nine months of operation, the site has recorded 108,000 sessions of extended periods of time by an individual on the site. Network of Care has been cited as a "best practice" in the President's New



“I am still in therapy working issues because recovery is a life long process. I have looked within at the person I am because I really wanted to recover.”

Freedom Commission Report on Mental Health. Maryland is adding a comprehensive veterans' portal to the state's Network of Care site to help service men and women returning from Iraq and Afghanistan with behavioral health needs obtain access to services.

Maryland Receives Grant to Realize the Full Potential of Telemental Health

Telemental Health helps ensure access to appropriate, high quality psychiatric services for minority, uninsured, unserved, and underserved individuals residing in seven rural Maryland jurisdictions. In May 2008, the federal Health Resources and Services Administration awarded MHA a three-year grant to purchase telemental health equipment and support further development of the system in rural areas.

Telemental health is also being used by Correctional Mental Health Services in detention centers in several jurisdictions and in selected state correctional facilities to enhance long distance training and referral processes.

Veterans Initiative Focuses on Services Needed for Reintegrating Veterans into Their Communities

In 2008, MHA implemented Maryland's Commitment to Veterans, which is a three-year collaborative partnership among the Department of Health and Mental Hygiene (DHMH), the U.S. Department of Veterans Affairs, the Maryland Department of Veterans Affairs, and the Maryland Defense Force. The project, funded by the State of Maryland, is designed to help combat veterans and their families obtain the behavioral health services they need upon the veteran's return from conflict. The primary objective is helping Veterans of the Iraq and Afghanistan conflicts link to eligible services within the US Department of Veterans Affairs.

MHA Introduces Mental Health First Aid® to the U.S.

MHA, in collaboration with the Mental Health Association of Maryland (MHA MD) and On Our Own of Maryland (OOOMD), has adopted the

Mental Health First Aid® (MHFA) program to educate the general public to recognize signs of an emerging mental illness or a mental health crisis and to help individuals with mental health problems obtain needed assistance. Since the launch of MHFA in Maryland in Fall 2008, a diverse group of over 800 Marylanders has been trained. MHFA originated in Australia, and MHA is leading a pioneering effort to adapt and implement the program in the United States in partnership with the Substance Abuse and Mental Health Services Administration (SAMHSA), the National Council for Community Behavioral Healthcare, and the State of Missouri. MHFA is analogous to traditional first aid programs, which have not historically incorporated mental health. The program is being presented across Maryland in a variety of settings, including schools and universities, as a public health initiative to build healthier communities.

MHA Launches Wellness Recovery Action Planning in Maryland

MHA, in collaboration with On Our Own of Maryland (OOOMD), began implementing Wellness Recovery Action Plan (WRAP) training and incorporating WRAP into all Wellness and Recovery Centers (consumer run centers) as a model for peer support. WRAP is a simple, widely accepted, evidence-based recovery tool tailored to meet individuals' unique needs. It is based on a conviction that people with mental health issues can have hope, exercise control over their lives, develop self-directed wellness plans, and recover. Thousands of consumers around the country have found that WRAP enables them to identify triggers and subtle warning signs that they are having troubles, and organize healthy responses to avert a crisis. Setbacks become opportunities to learn new responses and recover. WRAPs are living documents changed and updated as the authors grow and their situations change. To date, it is estimated that at least 300 Marylanders, including Wellness and Recovery Centers' staff and volunteers, have participated in the introductory WRAP training and have completed a personal Wellness Recovery Action Plan. There are also 51 trained WRAP facilitators, and 18 more are scheduled to be trained in the near future.



“I have been in an adult home for three years. I had no idea about how to go about leaving and starting my life over. I took WRAP® in February and now I have a plan and a way to do something I never thought I would be able to do. I found the courage I needed and the hope to try.”

Transformative Self-Directed Care Model Tested in Washington County

MHA continued to support the local Office of Consumer Advocates in Washington County as it manages and assesses the state's Self-Directed Care (SDC) pilot project, which began in FY 2007. Peer advocates help consumers develop and implement their own “recovery plans,” which include “directing” the use of their benefits to access both public mental health services and non-traditional support services. SDC provides flexible funding that allows consumers to step outside the PMHS and obtain the support and services they want, enabling them to attain personal recovery goals and become full-fledged members of their communities. The program currently serves over 40 people, and has had great success in securing consumers' independence and recovery, empowering them to make important decisions about their lives.

Housing Resources for Consumers Are Assessed

The Transformation Office and MHA worked with the Howard County CSA and the Technical Assistance Collaborative, Inc. (TAC), a Boston-based consulting firm, to conduct a comprehensive assessment of current housing programs and funding resources, and make recommendations for expansion of housing opportunities for priority consumer groups, including individuals with serious mental illness and those with co-occurring mental illness and substance abuse disorders. A central purpose of the assessment is to maximize use of existing funding and to identify new funding sources to expand affordable, safe, and integrated housing opportunities for individuals with mental illness.

Increased Support for Consumer Housing through the Bridge Subsidy Program

Over the past three years, the number of individuals with a mental illness who obtained affordable and safe housing through the Bridge Subsidy Pilot Program — a program that provides rent subsidies so mental health consumers can access traditional housing programs — has increased. The program continues to provide training for providers, CSAs, and new tenants so that residents can maintain their housing. The success of this pilot has led to its expansion from 10 to 15 counties. The State Plan provides that at least 57 individuals with a mental illness will be served by the end of FY 2009, with 12 individuals moving from residential rehabilitation programs (RRPs) to independent housing.

Main Street Housing Offers Creative Approach to Meeting Residential Needs

A subsidiary of On Our Own of Maryland, Main Street Housing is unique in the U.S. as a housing program run by mental health consumers. It also offers an innovative approach to housing, since consumers are not required to receive specific mental health services from the organization itself. This allows consumers a high degree of autonomy in selecting which mental health services they use and from which providers they receive them. Main Street Housing operates under a principle of “supportive accountability,” making consumers as accountable as anyone else for maintaining their tenancy; if problems arise, the organization intervenes in support of the consumer/tenant only to the extent necessary.

Main Street Housing currently provides 27 residential units for 56 tenants in nine counties across the state. With the help of Transformation, the organization is in the process of developing a management information system to track the consumers it serves, allowing it to monitor such variables as rental payments, inspections, and maintenance. This effort is likely to produce a computerized system which will be of interest to other specialized housing programs across the state and country.

Maryland Receives Award for Trauma-Informed Care in the Criminal Justice System

In FY 2008, MHA received the Healing Ourselves through Promises of Empowerment (HOPE) award from SAMHSA’s National Center for Trauma Informed Care (NCTIC) for Maryland’s leadership and commitment to providing trauma-informed care through its TAMAR (Trauma, Addictions, Mental health, And Recovery) Program. The TAMAR program provides treatment for incarcerated individuals who have histories of trauma and mental illness, and who may also have a co-occurring substance abuse disorder. The TAMAR Program, which served over 650 individuals in FY 2008, is located in nine county detention centers and at Springfield Hospital Center. TAMAR has also incorporated HIV/AIDS prevention strategies in many sites.



“In AA they say you need to chase recovery like you used to chase alcohol. I use that principle in my whole life. I chase my mental health recovery like my life depends on it, because it does. Life or death...it’s my choice.”



“My recovery started [with] God making me aware that I was created for a purpose. Then I came in contact with a criminal law judge in West Virginia. He made me take responsibility for my mental illness and my actions, and get help. The help I needed was my mother, people in recovery from mental illness, and Helping Other People through Empowerment (a program for people who are homeless and have mental illness).”

Special Program for Mothers with Co-Occurring Disorders in Criminal Justice System

This year, MHA collaborated with the Department of Public Safety and Correctional Services and an array of other stakeholders to create a new statewide transitional program for pregnant women with mental illness and/or substance-abuse disorders who have a history of trauma and who are involved with the criminal justice system. The initiative, known as the Chrysalis House Healthy Start Program, consists of a 16-bed diagnostic and residential facility in Baltimore City for pregnant and post-partum women and their babies. Pregnant women are referred by the courts, the Office of the State’s Attorney, the Office of the Public Defender, defense attorneys, correctional facilities or DHMH.

Consumers Receive Support for Health Care Coverage While Employed

In FY 2008, a total of 455 consumers received training on the Employed Individuals with Disabilities (EID) program. EID enables consumers to return to work and continue to qualify for Medicaid by paying monthly premiums ranging from \$0 to \$55, depending on the level of countable income. MHA works with On Our Own of Maryland to implement provider-specific and consumer-focused workshops on the EID program. This program is offered to all supported employment sites, psychiatric rehabilitation programs, NAMI affiliates, and On Our Own affiliates.

Community and Residential Services – Older Adults

Critical Groundwork is Being Laid for Improving Mental Health Services for Older Consumers

Using its Transformation grant, MHA has retained a consultant with special expertise in the area of mental health services for older adults and their families to develop strategic plans for this priority population. Working with a broad range of stakeholders and experts in the field of geriatric mental health, the consultant has mobilized resources to collect data on the current mental health needs of older Marylanders, using the state's Medicaid database; to survey residential service providers to determine the characteristics and service needs of older people with both physical health needs and psychiatric disorders; to assess the current system of mental health services for older adults; and to identify best practices for addressing the needs of older consumers.

Community Services – Child and Adolescent Services

Child and Adolescent Mental Health Institute Forges Ahead with Evidence-Based Practices

In FY 2007, in collaboration with the University of Maryland, the Johns Hopkins University, and the Maryland Coalition of Families for Children's Mental Health, MHA launched the Maryland Child and Adolescent Mental Health Institute to promote evidence-based practices (EBPs) for children and adolescents in Maryland through research, practice, and education. The Institute completed its first year of operations in FY 2008 with a major report which set forth recommendations for EBP development including development and implementation of a trauma-informed system of care which incorporates treatment foster care,



“We face everything and recover. We’re heroes, because we’re facing it. I get out of my house and “do” recovery. My whole life is my recovery.”



“Why do people hear our stories and feel sad, when they should feel proud of who we are?”

“In order to understand how I cope, you have to respect my culture...youth culture.”

evidenced-based family therapy, respite care, changes in child psychiatric rehabilitation practice, and school-based and early childhood mental health services. Since then, MHA and its partners have begun the work on implementing trauma-informed care, treatment foster care, psychiatric rehabilitation services, and respite care.

Youth MOVE Program Produces Young Consumer Advocates

In June 2007, Maryland established the first state chapter of Youth MOVE (Motivating Others through Voices of Experience), a national organization that supports growth and development of young people with mental illness, to help them become leaders in advising the PMHS on issues of policy development and program improvement for services for youth. A total of 65 youths from across the state are actively involved in this initiative.

Maryland Receives Federal Approval to Expand Services To Keep Children in the Community with Their Families

In FY 2008, projects offering home and community-based services to children and youth under 18 with serious emotional disturbances, known as Wraparound Services, continued in the initial two sites (Baltimore City and Montgomery County) and expanded to include two additional counties, St. Mary's and Wicomico. In February 2008, Maryland was selected by the Center for Medicare and Medicaid Services to participate in a demonstration project to develop community alternatives to out-of-home care. This project will further expand wraparound services throughout Maryland.

Suicide Prevention Efforts Focus on Youth

MHA's youth suicide prevention efforts made continued progress in a number of areas during the past year. The Maryland Youth Crisis Hotline Network implemented a new multi-site information management system, a nationally recognized prototype known as iCarol; and MHA updated Maryland's Youth Suicide Prevention Plan, Linkages to Life, to

provide more effective statewide interventions to prevent youth suicide. In addition, MHA conducted an analysis of youth suicide trends by jurisdiction to compare Maryland's jurisdictions, using the most recent data available from the Centers for Disease Control and Prevention. MHA also obtained a federal grant totaling \$1.5 million over three years to enhance the Linkages to Life program through development of local partnerships in suicide prevention and intervention.

Maryland Receives More Than Ten Million Dollars in Federal Support for Mental Health Interventions for Children in Foster Care

In September 2008, Maryland was awarded two major federal grants to develop specialized mental health services for children in foster care in September 2008. The first grant, a six-year allotment totaling \$8.6 million, is for MD CARES (Maryland Crisis Intervention and At Risk for Escalation Diversion Services), whose goal is to improve mental health outcomes for children and youth served by the foster care system in Baltimore City. This program will serve up to 40 youth at one time, each for an average of 15 months. It will also deliver capacity building services to local jurisdictions throughout Maryland such as training, technical assistance, policy and fiscal analysis, and outcome monitoring. The second grant, a five-year allotment totaling \$1.8 million, is for Maryland KEEP (KEEPing foster and kinship parents trained and supported). The goal of this program is to strengthen the network of foster families, decrease placement disruptions, and increase permanency for children in foster care. This intervention will focus on children between ages 5 and 12 in two jurisdictions, with an ultimate goal of statewide replication.

Inpatient Services

Services for Traumatic Brain Injury Receive Priority Attention

MHA is Maryland's lead agency for coordinating services for people with Traumatic Brain Injury (TBI), monitoring community placements and plans of care for this population. This program operates at capacity and has a waiting list of 45 individuals. Through a home- and community-based services waiver, Medicaid funds are available to secure specialized community placements for up to 30 individuals with TBI. In addition, a grant from the federal Maternal and Child Health Bureau is being used to fund TBI resource coordination programs in five Maryland counties. Efforts are underway to develop a database for the TBI program.

Action Taken to Reduce Use of Seclusion and Restraint among Children, Youth, and Adults

The University of Maryland's Mental Health Systems Improvement Collaborative (MHSIC) has worked with MHA to significantly reduce the use of seclusion and restraint in Maryland's residential and inpatient care settings for children and adolescents. One of the products of that effort is the Child/Adolescent START (Systematic Training Approach for Refining Treatment) Manual, used to train staff throughout the facilities. That Manual has been revised for use in the adult population in inpatient facilities, and incorporates a broader focus on trauma-informed, consumer-driven, and recovery-based care. As the Seclusion and Restraint Reduction/Elimination effort moves into the adult facilities, MHA will begin by targeting one facility (Springfield Hospital Center), work to reduce seclusion and restraint there, and have that facility serve as a Center of Excellence and a model for other facilities. The Seclusion/Restraint Project Coordinator is providing intensive consultation and technical assistance to Springfield Hospital Center.

All MHA Facilities Go Totally Smoke Free

By the fall of 2008, all MHA facilities (state offices and state psychiatric facilities) became smoke-free. In an effort to help patients and staff make the transition to a "smoke-free" environment, smoking cessation training sessions and other supports were offered over the course of the year. Recent studies estimate that individuals with mental illness die 25 years earlier than those without mental illness; this early mortality is linked in large part to modifiable high-risk behaviors such as smoking. Recognizing the implications of this research, MHA adopted the smoke-free policy.

Henry's Story of Recovery

My recovery story has been a lifelong journey, and it is only within the last few years that I have felt a true sense of control over my life. My mental illness has put extreme stress on my marriage, ended many friendships, disabled me physically, and jeopardized my employment. In retrospect, the costs seem overwhelming. But I have finally arrived at a place in life where I not only understand my mental illness fairly well but also have attained a large measure of control over it. To me, that is real recovery. My diagnosis explains part of my life but no longer defines me as a human being.

I am diagnosed as Bipolar, and although it seems that the onset of my illness began during my adolescence, I did not receive the diagnosis and unlock the puzzle of why I am so different until I was almost 42. Beginning in my early 20s, I began to engage in binge drinking, where I drank to excess on one night every few weeks. It appears that I was using alcohol to "self-medicate." Before I understood my condition, it seemed to be the only way to experience some relief—although at an unacceptable cost.

My manic depression has been described as "rapid cycling," and looking back, a clear pattern emerges. Every few weeks, a combination of mania and alcohol loosened my inhibitions and I engaged in behavior that appalls me now, as I reflect on it from the perspective of recovery. During these times, I seemed to be rebelling against every form of authority and rejecting much of what I value in life.

To what do I attribute my recovery? There are many factors, but first and foremost, I have to recognize the love, understanding, and support of my wonderful wife. During the many years of our marriage, I have given her many reasons to leave me, but she has loyally and affectionately stayed with me, despite the burden to which I have subjected her. I am also grateful for an exceptionally compassionate, knowledgeable psychiatrist who has rescued me from the brink of suicide several times and patiently worked with me to identify the best combination of psychotropic drugs to support my recovery.

While my mood swings are far less extreme than they once were, I do feel a need to be constantly vigilant. I realize that relapse is always possible—it can and does happen at any time. Yet I have also reached a point where I can openly discuss my illness with others, especially other consumers, family, and close friends.

To those of you struggling with mental illness, I wish you success in your own journey to recovery. Please understand that there are many others with similar experiences, engaged in similar journeys, and know that you need not be alone. Keep searching until you find the path that will enable you to reach and maintain recovery—and do not succumb to the temptation to go it alone.



MHA Values:

We value:

- 1 Basic Personal Rights**
- 2 A System Responsive to the People It Serves**
- 3 Empowerment**
- 4 Family and Community Support**
- 5 Least Restrictive Setting**
- 6 Working Collaboratively**
- 7 Effective Management and Accountability**
- 8 Local Governance to Increase Efficiency, Congruence, and Continuity of Services**
- 9 Staff Resources**
- 10 Community Education**

The services and facilities of the Maryland State Department of Health and Mental Hygiene (DHMH) are operated on a non-discriminatory basis. This policy prohibits discrimination on the basis of race, color, sex, or national origin and applies to the provisions of employment and granting of advantages, privileges, and accommodations.

The Department, in compliance with the Americans with Disabilities Act, ensures that qualified individuals with disabilities are given an opportunity to participate in and benefit from DHMH services, programs, benefits, and employment opportunities.



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